STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155278	B. WING		12/05/2012	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER	-BLOOMINGTON		BURKS DR MINGTON, IN 47401		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE	
1 0000						
	This visit was for	a Recertification and	F0000	Disclaimer Statement:Submis		
	State Licensure S	Survey.		of the Plan of Correction is no admission that the deficiency	ot an	
				exists or that they were cited		
	This visit was in o	conjunction to the		correctly. This Plan of Correct is a desire to continuously	etion	
	Investigation of C	Complaint		enhance the quality of care as	nd	
	IN00119843.			services provided to our resid	ents	
				and is submitted solely as a requirement of the provision of	of .	
	Survey dates:			Federal and State law."This F	Plan	
	November 26, 27	7, 28, 29, 30, and		of Correction constitues a write	tten	
	December 03, 04	1, and 05, 2012		allegation of substantial compliance with Federal		
	,			Medicare and Medicaid		
	Facility number:	000177		requirements"		
	Provider number					
	AIM number: 10					
	7 tilvi riamber. To	020000				
	Survey team:					
	Sharon Whitema	n, RN, TC				
	Susan Worsham					
	Marla Potts, RN					
	Diana McDonald	, RN				
	Cheryl Mabry, Ri					
	, , , , ,					
	Census bed type	:				
	SNF/NF: 134					
	Total: 134					
	Census payor typ	oe:				
	Medicare: 13					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Facility ID:

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If continuation sheet

PRINTED: 01/09/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155278		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/05		
	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE URKS DR INGTON, IN 47401	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	Medicaid: 107 Other: 14 Total: 134 These deficiencie	s also reflect state ccordance with 410 empleted on					

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Event ID: Z9SG11

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STATEMENT OF DEFICIENCIES X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155278	B. WIN			12/05/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			155 E E	BURKS DR		
	LIVING CENTER-I				/INGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
F0241 SS=D	483.15(a) DIGNITY AND RI	ESPECT OF					
33-D	INDIVIDUALITY	231 201 01					
	_	promote care for residents					
	•	n an environment that					
		ances each resident's					
	dignity and respe or her individuality	ct in full recognition of his y.				ļ	
	Based on obse	rvation, record review,	F02	41	The corrective action		01/03/2013
	and interview tl	he facility failed to			accomplished for Resident #54		
	ensure a reside	ent was provided			found to have been affected by	y	
	privacy with pe	rsonal care, for 1 of 40			the deficient practic are as follows: LPN #6 and CNA #7		
	• •	met the criteria for			were immediately in-serviced of	n	
	dignity This ha	ad the potential to			providing privacy with persona		
	• ,	sidents who resided on			care and provided disciplinary		
		he facility census of			action by the Unit Manager up	on	
	134. (Resident				notification of the deficient		
	134. (INESIDEIIL	#54)			practice. 11/28/12 2. All		
	Cindings indud	la.			residents who receive assistar		
	Findings includ	e.			from staff with toileting have the postential to be affected by this		
	0 44/00/40	0.40			deficient practice. 3. The	,	
		9:18 a.m.; upon			Alzheimer's care staff were		
	•	mentia unit, Resident			educated by the Alzheimer's C	are	
		ved to be sitting on the			Director on Novemeber 28th 2		
		ining room bathroom.			regarding providing dignity and	i	
	CNA #7 and LF	PN #6 were present in			privacy while providing care Direct Care Staff that work		
	the bathroom v	vith Resident #54. The			outside the Alzheimer's Care		
	door to the batl	hroom was observed to			Unit were in-serviced by the		
	have been fully	opened, exposing the			Director on Clinical Education	on	
	•	nt other residents in the			November 29th 2012. Direct C	are	
		x females and two			staff will be re-inserviced.		
	•	as to anyone walking			01/02/13. New/Future staff will		
	up and down th				be educated in regards to dignary and privacy during general	ıty	
					orientation.4. The Unit		
	During interview	w with the Unit			Managers/Designee will condu	ıct	
	•	/29/12 at 1:00 P.M.,			daily random audits of care to		
	•	ger indicated both staff			ensure resident's dignity is bei	ng	
	uie Onii Manag	ger mulcateu butii Staii			preserved while care is being		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 12/05/	ETED
ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE SURKS DR IINGTON, IN 47401		
SUMMARY S' (EACH DEFICIEN REGULATORY OR Members [LPN would be, "writt related to not he door closed to	BLOOMINGTON TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) #6 and CNA #7] ten up" for dignity aving the bathroom provide privacy. Ford for Resident #54 for 11/29/12 at 10:42 st recent MDS set] assessment, indicated the resident spritive impair and was staff for decision MDS also indicated equired extensive staff in transfers and toilet colan, dated 6/9/10, colem, "restorative leting." Approaches ere not limited to the bathroom when I get ffer naps, before bed		155 E B		erns de d	(X5) COMPLETION DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155278	B. WIN			12/05/	2012
	ROVIDER OR SUPPLIER LIVING CENTER-I			155 E B	ADDRESS, CITY, STATE, ZIP CODE BURKS DR MINGTON, IN 47401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0244 SS=E	When a resident of facility must listent the grievances ar residents and fampolicy and operat resident care and Based on interview	COMMENDATION or family group exists, the n to the views and act upon nd recommendations of nilies concerning proposed ional decisions affecting I life in the facility. w and record review	F02	44	Grievance dated 10-16-12 resolved regarding rooms bein		01/03/2013
	the facility failed to	o ensure grievances			cleaned daily, floors being swept		
	voiced by the resid	dent council were			and moped, windows and		
	acted upon. This	had the potential to			curtains being cleaned. 11/27/122. All residents have the	the	
	affect all residents	s who resided in the			potential to be affected by this		
	facility and wished	d to attend resident			deficient practice.3. Departme		
	facility and wished to attend resident council. Findings include:				Heads were re-educated on the grievance process and expectations on grievances by the Executive Director.01/02/1 Social Services and Activities Director were educated on the	y 13	
	During interview o	on 11/29/12 at 2:15			grievance process from reside council by the Executive Direc		
	p.m., with the Res	sident Council			12/06/12 All grievances will be		
	President, Reside	nt #49, he indicated			brought to morning Departmer	nt	
	meals were anywh	here from 45			Head meeting daily 5X a week be reviewed for resolution.	(10	
	minutes to 2 hours	s late, and had been			Grievances received on the		
	for two months. F	Resident #49			weekend will be put in the Soc Services box. Grievances not		
	indicated last Satu	urday Church was			resolved within the 5 days will		
	supposed to be at	2:00 p.m., and the			discussed on why they are not		
	volunteers had to	stand and wait to			resolved and Social Services viget back with the resident or	VIII	
	start Church, beca	ause the meal was			family member on what is bein		
	so late, making the	e activity late too.			done to resolve the grievance.		
Resident #49 indicated this had been	cated this had been			Resident and or family member will be contacted once the	1		
	brought up during	resident council			grievance is resolved with the outcome of grievance.		

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 12/05/	ETED
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/00/	
NAME OF F	PROVIDER OR SUPPLIER				URKS DR		
GOLDEN	I LIVING CENTER-	BLOOMINGTON		BLOOM	IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	meetings, but noth	ning had been			Grievances that come from		
	brought back to th	e council. Resident			resident council will still be reviewied at the next resident		
	#49 indicated the	facility responded to			council for their approval of th	е	
	maybe half the res	sidents' grievances.			resolution. All grievances fror resident council will be written		
	Resident #49 indi	cated part of the			separate not as a group if it		
	time the council ju	st never heard a			pertains to missing clothes, ro not clean, not getting a showe		
	thing back nor sav	v any changes			and etc. Residents were		
	made. Resident #	449 indicated the			educated on the Grievance process on 12/18/12 at the		
	Activity Director he	elped the council			Resident Council Meeting and	l	
	with notes and things.				were in agreement with the		
	During interview was Director on 11/29/indicated grievand a form and given to department head a Activity Director in were suppose to be date to be taken to meeting, but some done and sometime.	with the Activity 212 at 2:25 p.m., she ces were placed on to the appropriate for a response. The idicated the forms be back by a certain to the next month etimes this was hes not. The idicated sometimes eads just did not			process.4. The Executive Director will review the grieval log weekly for timely follow-up Social Services Director will monitor for any negative trend patterns and report grievance and follow-up to the Quality Assurance Committee monthl for further recommendations. 01/03/13	s or s	
	The Activity Direct department responsindicated, "date of 10/16/12." Docume form further indicated.	nse form which council meeting					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/05/	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE URKS DR IINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	head on 10/19/12 to resident council 10/26/12, concern cleaned daily, floor swept and moped curtains are dirty, The response was resident council or only response was missing clothes. The Activity Direct not know about th concerns as the di those meetings im regular council me no idea if notes was During interview was Facility Administrat 222 p.m., the HFA could find no note committee.	response due back representative s were "room not rs are not being , windows and missing clothes." s returned to the n 11/27/12. The s to the concern of There was no eaning. for indicated she did the food committee sietary manager held the mediately after the the taken or not. with the HFA [Health ator] on 11/29/12 at a indicated she s from the food		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
	2009, was provide	ed by the Director of I2 at 9:00 A.M. The If two or more				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278			(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 12/05/2	ETED
	PROVIDER OR SUPPLIER		B. WIIV	155 E B	DDRESS, CITY, STATE, ZIP CODE URKS DR IINGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	Departmental Resis to be utilized. Thave a plan to concompleted and sign appropriate departmen signed by the Director] at the ne	sponse Form [DRF] The DRFs need to rect the situation gned by the tment head, and e ED [Executive ext Council Meeting. decide whether the resolved [at least at agrees] or and needs to be g the same oncerns also get		IAU			DATE

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155278	B. WIN			12/05/	2012
	ROVIDER OR SUPPLIER			155 E B	ADDRESS, CITY, STATE, ZIP CODE BURKS DR MINGTON, IN 47401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services prov facility must be pr persons in accord written plan of cal		F02	82	1 The Unit Manager immedia	toly	01/03/2013
	record review the	ation, interview, and facility failed to	coorected the positioning		coorected the positioning of the cathether tubing for Resident		01/03/2013
	ensure nursing sta	aff followed a			#139. The facility began		
	resident's care pla	an for urinary			in-servicing staff immdeiately catheter tubing positioning.2.		
	catheter positioning	ng for 1 of 3			residents who have a indwelling		
	residents reviewed	SVICTOR WITO THE CITE	urinary catheter have the poten	urinary catheter have the potential to be affected by this deficient			
	criteria for having	a urinary catheter.			practice.3. Direct care staff will	l be	
	This contributed to	o the resident			in-serviced on positioning of		
	having received M	lacrobid [an	catheter tubing. 01/02/12 New/future staff will be educa	ed			
	anti-infective med	ication often used to			on positioning of catheter tubir	ng	
	treat a urinary trac	ct infection].			during general orientation.4. T	he	
	(Resident #139)				Unit Manager/Designee will conduct random audits of care ensure resident's catheter is	to	
	Findings Include:				positioned properly and not touching the floor. The audits be conducted 5X a week to	wilt	
	On 11/29/12 at 10):44 a.m., wound			include all shifts and weekends by the Unit		
	care was observe	d to be provided for			Manager/Designee for 4 week		
	Resident #139. R	Resident #139 was			then weekly for 8 weeks. Audi will include all shifts and	its	
	observed to rest in	n bed with 1/2 side			will include all snifts and weekends. The audits will be		
	rails in the up pos	ition. Resident			turned into the Director of Nurs	-	
	#139 had a urinar	y catheter drainage			weekly for review. Any negative findings will be reported to the	/e	
	bag, which was ob	bserved to be			Quality Assurance Committiee		
	hanging on the sid	de rail of the bed			monthly for 3 months. Any trends		
with urine back flowi		owing in the tubing.			or patterns identified will have written action plan implemente		
	Unit Manager #2 was observed to				The Quality Assurance		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 12/05/	ETED	
NAME OF D	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
					BURKS DR		
	I LIVING CENTER-I				1INGTON, IN 47401		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	remove the draina	ige bag and to hook		Committee will determine if further monitoring will be nee after the 3 month period. The		needed	
	it on the bed frame	e.					
	On 11/26/12 at 10:05 a.m., Resident				Quality Assurance Committee make the determination after reviewing the prior 3 month at		
	#139 was observe	ed resting in bed.			if further auditing is needed. It	•	
	The indwelling cat	theter drainage			further monitoring is needed we continue on a month to month		
	tubing was observ	ed dragging on the			basis.5. 01/03/13	•	
	floor. Dark yellow	cloudy urine was					
	observed in the ca	atheter tubing.					
	#139 was observed dining room seate Resident #139 was urinary drainage to the floor. The tubbe draining dark y sediment and spe	d in a wheel chair. Is observed to have ubing dragging on ing was observed to ellow urine with cks of red.					
		s observed to drink					
	3 complete glasse	Resident #139 did					
		ins or symptoms of					
	being in pain while	• •					
	dining room.						
	Ü						
	During interview o	f CNA #4 on					
	11/26/12 at 12:10	p.m., CNA #4					
	indicated Residen	t #139's urine did					
	look like it had mu	cous and blood in					
	it.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	TIPLE CON	NSTRUCTION	(X3) DATE S COMPLE	
ANDILAN	or correction	155278	A. BUILDI	NG	00	12/05/2	
			B. WING S	TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				URKS DR		
GOLDEN	I LIVING CENTER-I	BLOOMINGTON	E	BLOOMI	INGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	REGULTION	ESC IDENTIFICATION OF THE SECURITION	1	110			DITTE
	On 11/30/12 at 8:	27 a.m. and 10:01					
	a.m., Resident #1	39 was observed					
	resting in bed. Re	esident #139's					
	indwelling cathete	r drainage bag and					
	tubing were obser	ved to be on the					
	floor. A dignity ba	g was observed					
	hanging on the re	sident's bed rail.					
	The catheter was	draining dark yellow					
	urine. Resident						
	#139 did not exhib	oit and signs or					
	symptoms of bein	g in pain during this					
	assessment.						
	0 40/00/40 40						
	On 12/03/12 at 9:						
	#139 was observe	_					
		e up position. The					
	resident's urinary	•					
		over the top of the					
	resident's bed rail	_					
	_	e tubing. The tubing					
	was draining dark	amper colored					
	urine.						
	Interview of RN #	1 on 12/03/12 at 9:					
	32 a.m., indicated	she was not aware					
	the tubing was over	er the top of the					
	railing and she wo	•					
	immediately.						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155278	A. BUIL	DING	00	COMPL	
		100276	B. WIN			12/05/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-I	BLOOMINGTON			URKS DR IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i	DATE
	Review, on 12/5/1	2 at 9:30 a.m., of					
	Resident #139's c	linical record					
	indicated the follo	wing:					
	A Medical Diagno	ses list indicated					
	Resident #139 ha	d diagnoses which					
	included, but were	e not limited to,					
	Necrotizing Fascit	is [death of tissue],					
	other specified dis	sorders of urinary					
	tract, hypo-osmola	ality and/or					
	hyponatremia.						
	A physician's tele	phone order dated					
	11/30/12 indicated	d, "Obtain UA+ C&S					
	[Obtain urinalysis	and culture and					
	sensitivity of urine]."					
	-	•					
	A Progress Note of	dated 12/2/12,					
	indicated, "Partial	results received for					
		nd posted to chart.					
	Awaiting results."	•					
	.						
	A Urinalysis repor	t dated 12/02/12,					
	indicated the follo						
		· ·					
	Urinalysis - 12/02/	/12 -					
	Reference Range						
	Blood - 3						
	negative						
	PH urine - 7						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z9SG11

Facility ID: 000177

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CON		(X3) DATE S	
AND PLAN	OF CORRECTION	155278	A. BUILDIN	lG	00	COMPLI 12/05/2	
		100210	B. WING	PDEET AI	DDRESS, CITY, STATE, ZIP CODE	12/00/	2012
NAME OF P	PROVIDER OR SUPPLIER	l .			JRKS DR		
GOLDEN	I LIVING CENTER-I	BLOOMINGTON			INGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	12	AU	DEFICIENCE.		DATE
	7 Dratain 21						
	Protein - 2+						
	negative						
	Leukocytes - 4+						
	negative						
	WBC, UR - >50						
	negative	a da wata					
	Epithelial cell - mo	oderate					
	negative						
	Bacteria - Few						
	negative						
	An MDS [Minimun	n Data Setl					
	_	d 09/25/12, indicated					
	Resident						
	#139 had severe	cognitive					
	impairment and w	_					
	staff for daily deci	•					
	_	e assistance of staff					
		et use, and personal					
	hygiene. The MD	S indicated the					
	resident had no ui						
	infections during t	-					
	assessment.						
	An MDS dated 06	/12/12 and MDS					
	dated 05/08/12, in	ndicated Resident					
	#139 had no urina	ary tract infections					
	during the assess	ment time periods.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z9SG11

Facility ID: 000177

If continuation sheet Page 13 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155278	A. BUII	LDING	00	COMPLI 12/05/	
		133270	B. WIN		DDDEGG CITY CTATE TID CODE	12/03/	2012
NAME OF I	PROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	N LIVING CENTER-	BLOOMINGTON			IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
	Resident #139 wa	·					
	facility on 04/22/1	2 and clinical record					
	review indicated the	he resident did not					
	have a history of u	urinary tract					
	infections.						
	A care plan, dated	d 05/13/12 with a					
	target date of 01/2	10/13 indicated, "I					
	[Resident #139] h	ave a poor					
	response to other	s and the					
	environment and	limited ability to					
	communicate"						
	A care plan dated	05/03/12 with a					
	target date of 01/2	10/13 indicated, "					
	Alteration in elimin	nation of bowel and					
	bladder indwelling	urinary catheter					
	Keep drainage	bag of catheter					
	below the level of	the bladder at all					
	times and off floor	"					
	A Progress Note of	dated 11/30/12 at					
	4:02 p.m. indicate	d, "Resident					
	[Resident #139] h	as sediment noted					
	to catheter tubing	. No odor noted and					
	no c/o [complaint	of] flank pain					
	voiced. Consume	ed 480 CC [milliliters]					
	of fluids at lunch a	and has drank 2 - 16					
	oz [ounce] glasse	s of water at					
	bedside. New ord	der written to obtain					

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Event ID: Z9SG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/05/	ETED	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE BURKS DR IINGTON, IN 47401		
				IIING 1 OIN, IIN 47401		945)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	urine for UA+ [urir	nalysis] with C&S				
	[culture and sensi	tivity]. Med lab				
	notified, lab req [re	equisition] filled out.				
	Will obtain after di	nner et [and]				
	change F/C [Fole	Catheter] to obtain				
	sample."					
	A Progress Note of	dated 12/2/12 at				
	2:41 p.m. indicate	d, "Res [Resident				
	#139] f/c [Foley C	atheter] and ua				
	[urinalysis] obtain	ed using sterile tech				
	[technique], res to	lerated well."				
	A Progress note d	lated 12/02/12 at				
	3:05 p.m. indicate	d, "Partial results				
	received for UA+	and posted to chart.				
	Awaiting final resu	ılts."				
	During interview o	of RN #5 on				
	12/04/21 at 9:49 a	a.m., RN #5				
	indicated Residen	t #139's lab results				
	had just came in a	at 9:50 a.m. RN #5				
	indicated she was	printing a copy,				
	"right now" and we	ould take care of it.				
	RN #5 provided a	copy of the final				
	urine culture with	a reported date of				
	12/03/12 and a "la	ast reprint" date of				
	12/04/12. The rep	port indicated				
	positive growth for	r E-Coli [bacteria]				
	and urine was pos	sitive for 3+ blood,				

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Event ID: Z9SG11

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PRINTED: 01/09/2013 FORM APPROVED OMB NO. 0938-0391

TS5278 BUILDING SUND T2/05/2012		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A PULL DDG 00			(X3) DATE (COMPL	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Z+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."			155278				12/05/	2012
GOLDEN LIVING CENTER-BLOOMINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."	NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."								
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."				1	<u> </u>	IIINGTON, IN 47401		(W5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2+ protein, 4+ Leukocytes, moderate epithelial cells, and few bacteria. RN #5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."						(EACH CORRECTIVE ACTION SHOULD BE	_	
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#5 indicated she had just faxed the doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		2+ protein, 4+ Leu	kocytes, moderate					
doctor with the lab results. Review of Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		epithelial cells, and	d few bacteria. RN					
Tabor's Cylclopedic Medical Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		#5 indicated she h	ad just faxed the					
Dictionary 16 Edition indicated, E-Coli was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		doctor with the lab	results. Review of					
was normally nonpathogenic [not disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		Tabor's Cylcloped	ic Medical					
disease causing] in the intestinal tract but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		Dictionary 16 Editi	ion indicated, E-Coli					
but outside the body and particularly in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		was normally non	pathogenic [not					
in the urinary tract E-Coli, "is responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		disease causing] i	n the intestinal tract					
responsible for infection." A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		but outside the bo	dy and particularly					
A physician's telephone order, dated 12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		in the urinary tract	E-Coli, "is					
12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		responsible for infe	ection."					
12/04/12, indicated "Macrobid [anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."								
[anti-infective] 100 milligrams by mouth BID [twice daily] everyday for 7 days."		A physician's telep	phone order, dated					
mouth BID [twice daily] everyday for 7 days."		12/04/12, indicate	d "Macrobid					
days."		[anti-infective] 100) milligrams by					
		mouth BID [twice of	daily] everyday for 7					
3.1-35(g)(2)		days."						
3.1-35(g)(2)								
		3.1-35(g)(2)						

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If continuation sheet

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING	00	COMPL	ETED
		155278	B. WING			12/05/	2012
NAME OF B	DOLUDED OD CLIDDLIED		` Т	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			155 E B	URKS DR		
	LIVING CENTER-	BLOOMINGTON		BLOOM	INGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	483.25(d) NO CATHETER, BLADDER	PREVENT UTI, RESTORE					
	Based on the resi assessment, the firesident who enter indwelling cathetes the resident's clin that catheterization resident who is in receives appropriato prevent urinary restore as much resident who is	ident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless nical condition demonstrates on was necessary; and a ncontinent of bladder idet treatment and services of tract infections and to normal bladder function as					
	possible.		F031	5	The Unit Manager immedia	toly	01/03/2013
		ation, record review,	1 051		corrected the postioning of the	-	01/03/2013
	and interview the	•			catheter tubing for resident #13	39.	
	ensure a resident	•			The facility began in-servicing staff immediately on catheter		
	was positioned to				tubing positioning.2. All reside	ents	
	infection. This cor	ntributed to the			who have an indwelling urinary		
	resident being dia	gnosed with a			catheter have the potential to be affected by this deficient	oe .	
	urinary tract infect	tion. This finding			practice.3. Direct Care staff wi	ill	
	affected 1 of 3 res	sidents reviewed for			be in-serviced on positioning o	f	
	urinary catheters.	(Resident #139)			catheter tubing. 01/02/13 New/Future staff will be education regards to positioning of	ted	
	Findings Include:				catheter tubing during general orientation.4. The Unit Manager/Designee will conduct		
	On 11/29/12 at 10):44 a.m., wound			random audits of care to ensur	re e	
	care was observed	d to be provided for			resident's catheter is positioned properly and not touching the	u	
	Resident #139. T	he resident was			floor. Unit Manager/Designee		
	observed to rest in	n bed with 1/2 side			correct and provide education	on	
	rails in the up posi	ition. The resident			any identified problems. The audits to be conducted 5X a we	eek	
	had a urinary cath	neter drainage bag			to include all shifts and	,	
	which was observ	red to be hanging on			weekends for 4 weeks then 1X week for 8 weeks. Audits will the		
	the side rail of the	bed with urine back			turned into the Director of Nurs		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155278	B. WIN			12/05/2012	
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BURKS DR		
	I LIVING CENTER-	BLOOMINGTON	•		IINGTON, IN 47401		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE	
		ng. Unit Manager			weekly for review. Any negative		
	#2 was observed				findings will be reported to the Quality Assurance Committee		
	drainage bag and	to hook it on the			monthly for 3 months. Any tre	nds	
	bed frame.				or patterns identified will have written action plan implemente	l l	
					The Quality Assurance	ou.	
	On 11/26/12 at 10	0:05 a.m., Resident			Committee will determine if further monitoring will be need	ed	
	#139 was observe	ed resting in bed.			after the 3 month period. The		
	Indwelling cathete	er drainage tubing			Quality Assurance Team will review the audits for the prior 3	3	
	was observed dra	gging on the floor.			months to determine if further		
	Dark yellow cloud	y urine was			monitoring will be required after	er	
	observed in the ca	atheter tubing.			the 3 month period If further monitoring is needed will conti	nue	
					on a month to month basis.5.		
	On 11/26/12 at 11	1:59 a.m., Resident			01/03/13		
	#139 was observe	ed in the Station 2					
	dining room seate	ed in a wheel chair.					
	The resident was	observed to have					
	urinary drainage t	ubing dragging on					
	the floor. The tub	ing was observed to					
	be draining dark y	ellow urine with					
	sediment and spe	cks of red. The					
	resident was obse	erved to drink 3					
	complete glasses	of fluids while in the					
	dining room.						
	During interview of	of CNA #4 on					
	11/26/12 at 12:10	p.m., CNA #4					
	indicated Resident #139's urine did						
	look like it had mucous and blood in						
	it.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155278	B. WIN			12/05/2012	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE BURKS DR		
GOLDEN	I LIVING CENTER-	BLOOMINGTON			IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		27 a.m. and 10:01				5.1.2	
	a.m., Resident #1						
	resting in bed. Th	ne resident's					
	indwelling cathete	er drainage bag and					
	tubing were obser	rved to be on the					
	floor. A dignity ba	ag was observed					
	hanging on the re	sident's bed rail.					
	The catheter was	draining dark yellow					
	urine.						
	On 11/30/12 at 10):07 a.m., CNA #4					
	and LPN #3 were	observed to provide					
	personal care to F	Resident #139.					
	During the care, L	PN #3 was					
	questioned regard	ding Resident #139's					
	urine looking clou	dy and dark. LPN					
	#3 indicated the c	color of the resident's					
	urine, "comes and	d goes." LPN #3					
	indicated the resid	dent did not have a					
ı	UTI [urinary tract i	infectin] but					
	Resident #139 jus	st had sediment in					
	the urine.						
	Interview of the D	ON [Director of					
	Nursing] on 11/30)/12 at 3:25 p.m., the					
	DON indicated nu	rses should report if					
	residents have mu	ucous and blood in					
	their urine. DON	indicated she would					
	have the nurse ca	all the doctor. The					
	DON indicated the	e resident always					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
ANDILAN	or connection	155278	A. BUII			12/05/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	. 2, 30,	· -
NAME OF F	PROVIDER OR SUPPLIER	1			URKS DR		
	I LIVING CENTER-I	BLOOMINGTON			IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	drank all of her flu	· · · · · · · · · · · · · · · · · · ·					
	On 12/03/12 at 9:	30 a.m., Resident					
	#139 was observe	ed resting in bed					
	with 1/2 rails in the	e up position. The					
	resident's urinary	tubing was					
	observed hanging	over the top of the					
	resident's bed raili	ing with the urine					
	back flowing in the	e tubing. The tubing					
	was draining dark	amber colored					
	urine.						
	Interview of DN 4	1 on 12/03/12 at 9:					
		she was not aware					
	the tubing was over	•					
	railing and she wo immediately.	ould change it					
	miniculately.						
	Review, on 12/5/1	2 at 9:30 a.m., of					
	Resident #139's c	linical record					
	indicated the follow	wing:					
		40/00/40					
	Nursing notes from						
	-11/14/12 lacked o						
	-	nt #139's indwelling					
		s ever assessed or					
	documented on du	uring that time					
	period.						
	A puroing note de-	tod 11/19/12 at					
	A nursing note da	tea 11/18/12 at					

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Event ID: Z9SG11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155278	A. BUII	LDING	00	COMPLI 12/05/2	
		199276	B. WIN		PPPPG GYPY GT AT GO	12/05/.	2012
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	BLOOMINGTON			IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	18:36 p.m. indicated, "Note Text # 16						2.112
	foley [sic] catheter	r changed					
	secondary to obst	ructed flow,					
	immediate return	of cloudy yellow					
	urine noted. Resi	dent resistive while					
	procedure in prog	ress, sterile					
	technique maintai	ned."					
	A Medical Diagno	ses list indicated					
	Resident #139 ha	d diagnoses which					
	included, but were	e not limited to,					
	Necrotizing Fascit	tis [death of tissue],					
	other specified dis	sorders of urinary					
	tract, hypo-osmola	ality and/or					
	hyponatremia.						
	A physician's tele	phone order, dated					
	11/30/12, "Obtain	UA+ C&S					
	[urinalysis for cult	ure and sensitivity]."					
	A Drogress Note	datad 12/2/12					
	A Progress Note of						
		results received for					
	UA+ [The urinalys						
	Resident #139's urine was positive for						
	infection] and posted to chart.						
	Awaiting results."						
	A Urinalysis report dated 12/02/12,						
	indicated the follo						
		·					

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Event ID: Z9SG11

Facility ID: 000177

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278		LDING	NSTRUCTION 00	(X3) DATE COMPL 12/05/	ETED
	PROVIDER OR SUPPLIER		155 E B	DDRESS, CITY, STATE, ZIP CODE URKS DR INGTON, IN 47401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Urinalysis - 12/02/	/12 -				
	Reference Range					
	Blood - 3					
	negative					
	PH urine - 7					
	7					
	Protein - 2+					
	negative					
	Leukocytes - 4+					
	negative					
	WBC, UR - >50					
	negative					
	Epithelial cell - mo	oderate				
	negative					
	Bacteria - Few					
	negative					
	An MDS [Minimun	n Data Set]				
	assessment dated	d 09/25/12, indicated				
	Resident #139 ha	d severe cognitive				
	impairment, requi	red extensive				
	assistance of staff	f with transfers,				
	toilet use and pers	sonal hygiene. The				
	MDS indicated Re	esident #139 had no				
	urinary tract infect	ions during the time				
	of the assessmen	t.				
	An MDS dated 06	/12/12 and MDS				
	dated 05/08/12, in	dicated Resident				
	#139 had no urina	ary tract infections				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPLE	
	155278				12/05/2	2012
PROVIDER OR SUPPLIER						
I LIVING CENTER-I	BLOOMINGTON					
			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
`					TE	COMPLETION DATE
	·		mo			DATE
	mont time periods.					
Resident #139 wa	as admitted to the					
facility on 04/22/1	2 and clinical record					
review indicated tl	he resident did not					
have a history of ι	urinary tract					
infections.						
A care plan dated	05/13/12 with a					
target date of 01/1	10/13 indicated, "I					
[Resident #139] h	ave a poor					
response to others	s and the					
environment and I	limited ability to					
communicate"						
A care plan dated	05/03/12 with a					
target date of 01/1	10/13 indicated, "					
Alteration in elimir	nation of bowel and					
bladder indwelling	urinary catheter					
Keep drainage	bag of catheter					
below the level of	the bladder at al					
times and off floor	"					
A Progress Note of	dated 11/30/12 at					
4:02 p.m. indicate	d, "Resident					
[Resident #139] h	as sediment noted					
to catheter tubing.	. No odor noted and					
no c/o [complaint	of] flank pain					
voiced. Consume	ed 480 CC [milliliters]					
of fluids at lunch a	and has drank 2 - 16					
	PROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIEN REGULATORY OR during the assess Resident #139 was facility on 04/22/1 review indicated the have a history of unifections. A care plan dated target date of 01/2 [Resident #139] heresponse to other environment and communicate" A care plan dated target date of 01/2 Alteration in eliminal bladder indwellingKeep drainage below the level of times and off floor A Progress Note of 4:02 p.m. indicate [Resident #139] here catheter tubing no c/o [complaint voiced. Consume	DENTIFICATION NUMBER: 155278 PROVIDER OR SUPPLIER I LIVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to	IDENTIFICATION NUMBER: 155278 ROVIDER OR SUPPLIER I LIVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "Alteration in elimination of bowel and bladder indwelling urinary catheterKeep drainage bag of catheter below the level of the bladder at al times and off floor" A Progress Note dated 11/30/12 at 4:02 p.m. indicated, "Resident [Resident #139] has sediment noted to catheter tubing. No odor noted and no c/o [complaint of] flank pain voiced. Consumed 480 CC [milliliters]	ROVIDER OR SUPPLIER IDENTIFICATION NUMBER: 155278 ROVIDER OR SUPPLIER ILIVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, " Alteration in elimination of bowel and bladder indwelling urinary catheterKeep drainage bag of catheter below the level of the bladder at al times and off floor" A Progress Note dated 11/30/12 at 4:02 p.m. indicated, "Resident (Resident #139) has sediment noted to catheter tubing. No odor noted and no c/o [complaint of] flank pain voiced. Consumed 480 CC [milliliters]	DEPOSITION IDENTIFICATION NUMBER: 155278 REVIDING 155278 REVIDING 2. WING 155278 STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON 1147401 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate"	ROYIDER OR SUPPLIER ROVIDER OR SUPPLIER RUVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) during the assessment time periods. Resident #139 was admitted to the facility on 04/22/12 and clinical record review indicated the resident did not have a history of urinary tract infections. A care plan dated 05/13/12 with a target date of 01/10/13 indicated, "I [Resident #139] have a poor response to others and the environment and limited ability to communicate" A care plan dated 05/03/12 with a target date of 01/10/13 indicated, "I [Resident in elimination of bowel and bladder indwelling urinary catheterKeep drainage bag of catheter below the level of the bladder at al times and off floor" A Progress Note dated 11/30/12 at 4.02 p.m. indicated, "Resident #139] has sediment noted to catheter tubing. No odor noted and no c/o [complaint of] flank pain voiced. Consumed 480 CC [milliliters]

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/05/	ETED
	PROVIDER OR SUPPLIER		p. wii.	STREET A	URKS DR UNGTON, IN 47401	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	oz [ounce] glasse:	s of water at ler written to obtain					
	urine for UA+ [urin						
	[culture and sensi	tivity]. Med lab					
ı	notified, lab req [re	equisition] filled out.					
	Will obtain after di	nner et [and]					
	change F/C [Foley	Catheter] to obtain					
	sample."						
	A Progress Note of	dated 12/2/12 at					
	2:41 p.m. indicate	d, "Res [Resident					
	#139] f/c [Foley C	atheter] and ua					
	[urinalysis] obtain	ed using sterile tech					
	[technique], res to	lerated well."					
	A Progress note d	lated 12/02/12 at					
	3:05 p.m. indicate						
		and posted to chart.					
	Awaiting final resu	ılts."					
ı	During interview of	of RN #5 on					
	12/04/21 at 9:49 a	a.m., RN #5					
	indicated Residen	t #139's lab results					
	had just came in a	at 9:50 a.m. RN #5					
	indicated she was						
	_	ould take care of it.					
	RN #5 provided a copy of the final						
		a reported date of					
		ast reprint" date of					
	12/04/12. The rep	port indicated					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 12/05/2012	
	100270		B. WIN		DDDDGG CITY CTATE TID CODE	12/03/	2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE URKS DR		
GOLDEN	I LIVING CENTER-	BLOOMINGTON			INGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	positive growth fo	·					
	and urine was pos						
	_	ukocytes, Moderate					
	epithelial cells and	-					
	Megan indicated s	she had just faxed					
	the doctor with the	e lab results. Review					
	of "Tabor's Cylclo	pedic Medical					
	Dictionary 16 Edit	ion" indicated,					
	E-Coli was normally nonpathogenic						
	[not disease causing] in the intestinal						
	tract but outside tl	he body and					
	particularly in the urinary tract E-Coli						
	"is responsible for	infection."					
	A physician's tale	nhana ardar datad					
		phone order, dated					
	12/04/12, indicate [anti-infective] 100						
		daily] everyday for 7					
	days.	daily] everyddy for 7					
	,						
	Documentation tit	led "Infection					
	Surveillance Data	Collection Form"					
	was provided by t	he DON on					
	12/05/12 at 10:17	a.m. This form					
	indicated, "Cath	eterized					
	ResidentRequir	res two of the					
	following sympton	ns to be designated					
	as an infection:F	ever (>100.4) or					
	chillsNew flank	or suprapubic pain					
	or tendernessCl	hange in					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155278	A. BUILDING	00	COMPLETED 12/05/2012
100270			B. WING	ADDRESS, CITY, STATE, ZIP CODE	12/00/2012
NAME OF P	PROVIDER OR SUPPLIER	R		BURKS DR	
	I LIVING CENTER-		BLOOM	MINGTON, IN 47401	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
		urineChange in			
	mental status (e.g	g. confusion) or			
	change in function	nal status (e.g.			
	incontinence)."				
	3.1-41(a)(2)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING (COMPLE			ETED		
155278		B. WIN	G		12/05/2	2012	
	ROVIDER OR SUPPLIER			155 E B	ADDRESS, CITY, STATE, ZIP CODE BURKS DR IINGTON, IN 47401		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F0362 SS=F	483.35(b)	ETARY SUPPORT		TAG	DETERMENT)		DATE
	The facility must	employ sufficient support tent to carry out the ietary service.					
	Based on observa	ation and interview,	F03	62	Residents meal will be serv	/ed	01/03/2013
	the facility failed to	o employ sufficient			within 15 minutes of the scheduled time. Residents wi	ll he	
	staff to carry out t	he functions of the			told if their meal is running bel		
	dietary departmer	nt, in that meals			so that they do nothave to sit a		
	were served late.				wait with nothing to do. Suffic Dietary support personnel will provided to get meals out on		
	Findings include:				time.2. All residents have the potential to be affected by this deficient practice.3. Dietary		
	During intervie	w on 11/29/12 at			Department will be educated of the importance of getting	on	
	2:15 p.m., with the	e Resident Council			residents meals out on time ar	nd	
	President, he indi	cated meals were			notifying the Executive Director/Designee if meals are	_	
	anywhere from 45	minutes to 2 hours			running behind so that we can		
	late, and had bee	n for two months.			share this information with our		
	The Resident Cou	uncil President			residents. Regional Manager Health Care Services will educ		
	indicated this con-	cern had been			dietary staff. 01/02/134. Dieta		
	brought up in resi	dent council but			Manager/Designee will meet v residents monthly to discuss	vith	
	nothing had chan	ged so far.			concerns and meal times. Food Committee notes will be kept and		
	During interview v	vith Resident #108			a copy given to the Executive Director.5. Dietary		
	on 11/27/12 at 8:5	53 A.M., indicated			Manager/Designee will report	to	
	meals were routin	ely late and had			the Quality Assurance Commi		
	been for a severa	I weeks. During			monthly any meals that were I and why for further	ate	
	interview with Res	sident #117 on			recommendations.6. 01/03/13	3	
	11/27/12 at 8:46 a	a.m, indicated					
	meals were late ro	outinely for several					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMI	E SURVEY PLETED	
		155278	B. WIN	G		12/0	5/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON				155 E B	DDRESS, CITY, STATE, ZIP CODI URKS DR IINGTON, IN 47401	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	weeks.						
	2. The Facility Ac provided on 11/26 list of meal times,	6/12 at 1:00 p.m., a					
	lunch was to be s	erved 11:55 a.m. on					
	Reminiscence, 12 Horizons, 12:30 p						
	Dining room and hot carts., with breakfast times for Horizons was 7:20						
	a.m. and hot carts						
	On 11/26/12 Hori	izons was observed					
	to have received t	their lunch trays at					
	12:40 P.M. [40 mi	inutes late] On					
	11/27/12 Reminis	cence was					
	observed to have	received their lunch					
	trays at 12:33 p.m	n. [approximately 35					
	minutes late]. O	n 11/27/12 the Main					
	Dining room was	observed to have					
	received their first	t tray at 12:48 p.m.,					
	with the last tray s	served at 1:22 p.m					
	Residents were o	bserved waiting for					
	the meal service f	from 12:15 p.m. until					
	the meal was serv	ved at 1:22 p.m.					
	Numerous resider	nts were heard to					
	comment on the la	ateness of meals,					
	and the desire for	the facility to just					
	tell them when to	be there so they did					
	not have to sit and	d wait with nothing					

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PRINTED: 01/09/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278		A. BUILDING B. WING	00		LETED 5/2012	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON			STREET A 155 E B	ADDRESS, CITY, STATE, ZIP CO BURKS DR MINGTON, IN 47401	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	to do.					
	See Federal/S for more informati staffing issues.	tate Deficiency 371 on related to				
	3.1-20(h)					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155278 NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (FACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401	COMPLETION
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-BLOOMINGTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 155 E BURKS DR BLOOMINGTON, IN 47401 ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
PROVIDER'S PLAN OF CORRECTION	COMPLETION
DRIVING I CACH DEPLOYENCY MIGT DE DRECEDED DY FILL DREEDY CACH CODDECTIVE ACTION SHOULD DE	
CROSS-REFERENCED TO THE APPROPRIATE	
F0371 483.35(i) SS=F FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	01/03/2013

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	ETED	
		155278	B. WIN			12/05/2	2012	
NAME OF I	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					BURKS DR			
GOLDEN	I LIVING CENTER-	BLOOMINGTON		BLOOM	IINGTON, IN 47401			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		·	+	IAG	kitchen sanitation 5X a week.		DATE	
		I. Dietary Manager			Evaluations will be completed			
	in Training #1 ind				an audit sheet and will be turn into the Excutive Director wek			
		lay to help out in the			for 12 weeks. At the end of 12	•		
	kitchen.				weeks the Quality Assurance			
					Committee will evaluate and determine if further monitoring	ı is		
	_	ur of the kitchen on			needed5. Executive	,		
	12/04/12 at 2:00 p	·			Director/designee will make a round in the kitchen 3X a wee	L		
	_	ing #1 present the			for 2 weeks, 2X a week for 2	K		
	following soiled areas/containers/kitchen equipment were observed:				weeks, 1X a week for 4 weeks			
					then 1X a month. Any identific			
					time. Executive Director will	iiat		
					report to the Quality Assuranc	e		
	The entire kitcle	hen floor continued			Committee any negative outcomes monthly for further			
	to remain soiled v	vith sticky matter.			recommendations.01/03/13			
	2. The doors of the	ne walk-in cooler						
	and walk-in freeze	er were observed to						
	be soiled with stic	ky/grimy buildup.						
	3. Three food car	ts were observed to						
	be soiled with gre	asy/grime buildup						
	on shelving and e	edges.						
	4. Five of five ope	en carts used to						
	carry food trays w	vere observed to be						
	soiled with dust/g	reasy buildup.						
	5. A rack which h	neld clean dishes						
	was observed to I	be soiled with						
	dust/dirt buildup.							
	6. A hand wash s	sink was observed to						
	be soiled with a b	uildup of scum.						
	7. A cart in the w	alk-in refrigerator						
	was observed to I	hold 2 trays						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
155278		A. BUII			12/05/		
<u> </u>			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				URKS DR		
GOLDEN	I LIVING CENTER-E	BLOOMINGTON		BLOOM	IINGTON, IN 47401		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		to be served to the		ing	· · · · · · · · · · · · · · · · · · ·		DATE
	_	rt was observed to					
	have dried food pa						
		ezer was observed					
	to have a a thick la	ayer of frost					
	[approximately 1 in	nch] on the sides of					
	the freezer and a	thin layer of frost					
	on frozen food box	xes.					
	9. Two milk coole	ers were observed to					
	have a build up of ice and milk spilled						
	in the bottom and	dirt/debris in the					
	bottom.						
	10. A metal table	holding flour and					
	sugar bins was ob	served to be soiled					
	with dirt and dust	and sticky matter					
	was observed on t	the outside of the					
	flour/sugar bins.						
	11. An ice cream	freezer was					
	observed with ice	buildup and dirt in					
	the bottom of the f	freezer.					
	12. A storage bin	which held cups					
	and lids was obse	rved to be soiled					
	with greasy/dusty	matter.					
	13. A storage bin	which held					
	sweetener/sugar p	packets was					
	observed to be so	iled with a					
	dusty/greasy film.						
	14. A toaster was	observed to have a					
	greasy/dusty build	lup on the top and					
	sides.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL	E CONSTRUCTIO)N	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155278	A. BUILDING	00		12/05/2012
			B. WING	ET ADDRESS, CI	ITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	(E BURKS DR		
GOLDEN	I LIVING CENTER-	BLOOMINGTON	BLC	OMINGTON,	IN 47401	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		OVIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-RE	EFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
		vs were observed to				
	have blackened b					
	edges.					
	16. A storage car	t which contained				
	clean trays was ol	bserved to be soiled				
	with dust buildup.					
	17. Metal vents o	ver the top of the				
	stove was observe	ed to be soiled with				
	dust buildup.					
	18. The top of the					
		iled with a greasy				
	film.					
	Internation of Distan	A:J- #40				
	Interview of Dieta					
	12/04/12 at 2:10 p	used to do the deep				
	cleaning in the kite	·				
	Dietary Aide #11					
	employee.	no longer was all				
	ompleyee.					
	3.1-21(a)(3)					
	() ()					

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OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155278	A. BUILDING B. WING	00	COM 12/0	TE SURVEY PLETED 05/2012		
		STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401					
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETION DATE		
c	OVIDER OR SUPPLIED LIVING CENTER- SUMMARY S (EACH DEFICIEN	CORRECTION IDENTIFICATION NUMBER:	CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING OVIDER OR SUPPLIER LIVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING B. WING STREET B. DOON PREFIX	CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO 155 E BURKS DR BLOOMINGTON, IN 47401 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL OUTPUT A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO 155 E BURKS DR BLOOMINGTON, IN 47401 PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE ACTION SI CR	CORRECTION IDENTIFICATION NUMBER: 155278 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR LIVING CENTER-BLOOMINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 155 E BURKS DR BLOOMINGTON, IN 47401 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		

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